Kansas Drug Utilization Review Newsletter

Health Information Designs, LLC ***Spring 2016***

Welcome to the Spring 2016 edition of the "Kansas Drug Utilization Review Newsletter," published by Health Information Designs, LLC (HID). This newsletter is part of a continuing effort to keep the Medicaid provider community informed of important changes in the Kansas Medical Assistance Program (KMAP).

Helpful Web Sites

KMAP Web Site
https://www.kmap-state-ks.us/

KDHE-DHCF Web Site
http://www.kdheks.gov/hcf/

KanCare Web Site
http://www.kancare.ks.gov/

Fee-For-Service (FFS) Helpful Numbers

Provider Customer Service (Provider Use Only)
1-800-933-6593

Beneficiary Customer Service
1-800-766-9012

KMAP PA Help Desk
1-800-285-4978

In This Issue:

Prescribing Opioids for Chronic, Non-cancer Pain

Prescribing opioids for chronic pain has become a common practice for primary care physicians (PCPs) outside of the setting of active cancer treatment, palliative care, and end-of-life. PCPs report concerns with insufficient training in prescribing opioids, the risk of opioid addiction, and managing patients with chronic pain. The Centers for Disease Control (CDC) has issued a guideline with recommendations for the non-pain specialist on prescribing opiates in an outpatient setting.

Chronic pain typically lasts longer than three months or what is considered longer than the normal tissue healing. The transition from acute pain to chronic pain is hard to predict and identify. This guideline is intended to inform PCPs prescribing pain medications for painful conditions that can or have become chronic.

The recommendations are grouped into three areas for consideration: 1) determining when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use.

Determining When to Initiate or Continue Opioids for Chronic Pain

The first option in treating pain is non-pharmacologic and non-opioid pharmacologic treatments, which can be effective in managing chronic pain in studies ranging from two weeks to six months in duration. Non-pharmacologic treatments can include physical therapy, weight loss for knee osteoarthritis, and CBT as a psychological therapy. Several guidelines recommend acetaminophen for the treatment of osteoarthritis and low back pain; in the correct candidates, non-steroidal anti-inflammatory drugs (NSAIDs) are also recommended as first-line in these conditions. First- and second-line recommendations for neuropathic pain include anticonvulsants (gabapentin, pregabalin, carbamazepine), tricyclic antidepressants (TCAs), and selective serotonin and norepinephrine reuptake inhibitors (SNRIs).

Before starting chronic opioid therapy, the PCP should establish treatment goals with the patient. Goals should include realistic goals for pain and function, how therapy will be discontinued, and if benefits outweigh risks. Chronic opioid use should only be continued if there are clinically meaningful improvements

Prescribing Opioids for Chronic, Non-cancer Pain cont.

in pain that outweigh risk to the patient's safety. Clinically meaningful improvement has been defined as 30% improvement in scores for both pain and function. Assessing benefit can also include monitoring progress toward patient-centered functional goals (e.g., attending family sports activities). Experts agree that PCPs can use validated instruments such as the three-item "Pain average, interference with Enjoyment of life, and interference with General activity" (PEG) assessment scale to track patient outcomes.

PCPs are encouraged to have honest discussions with patients. Conversations can include realistic and explicit benefits of opioids (e.g., opioids can reduce pain during short-term use but lacks evidence of improving pain or function with long-term use), emphasizing improvement in function as a primary goal when pain is still present, and common and serious side effects of opioids.

Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation

When opioids are needed for acute pain, usually three days' supply or less of an immediate-release opioid is sufficient; more than seven days is rarely needed.

Clinical evidence review did not find evidence that continuous, time-scheduled use of extended-release/ long-acting (ER/LA) opioids is more effective or has a lower risk of abuse/misuse than intermittent use of immediate-release (IR) opioids. Initiation of opioid therapy should include IR opioids instead of ER/LA opioids at the lowest effective dosage. High doses of opioids are considered to be ≥ 50 morphine milligram equivalents per day (MMED); carefully reassess individual benefits and risks when increasing to or above this dosage. Increasing to ≥ 90 MMED should be avoided or carefully justified. After initiation, patients should be evaluated within one to four weeks for benefits and harms or for dose escalation, then continually evaluated every three months.

ER/LA opioids should be reserved for opioid-tolerant patients (60 mg of morphine per day or MMED) and those who have received IR opioids daily for at least one week. If an ER/LA opioid is selected, methadone and/or fentanyl should not be the first choice. Methadone is associated with disproportionate numbers of overdose deaths relative to the frequency with which it is prescribed, cardiac arrhythmias along with QT prolongation, complicated pharmacokinetics, long and variable half-lives, and individual variability in pharmacodynamics. Fentanyl should be reserved for clinicians who are familiar with the dosing and absorption properties since the dosing effects are often misunderstood.

High quality studies for tapering protocols have not been found. Tapers reducing weekly dosage by 10%-50% of the original dosage have been recommended by other clinical guidelines, and a rapid taper over two to three weeks has been recommended in the case of a severe adverse event such as overdose. Tapers slower than 10% per week (e.g., 10% per month) also might be appropriate and better tolerated than more rapid tapers, particularly when patients have been taking opioids for longer durations (usually years). Of note, opioid withdrawal during pregnancy has been associated with spontaneous abortion and premature labor.

Assessing Risk and Addressing Harms of Opioid Use

Special populations, including those with sleep-disordered breathing (including sleep apnea), pregnant women, patients with renal or hepatic insufficiency, patients aged 65 years or older, patients with mental conditions, patients with substance use disorder, patients with prior nonfatal overdose, and offering of

naloxone to patients at a higher risk of overdose are all reasons to consider the risk of opioid use. Careful monitoring and testing (if applicable) is important and highly recommended.

It is recommended that PCPs to review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data. This helps to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. The PDMP data should be reviewed when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months. Urine testing is also recommended at initiation and at least annually.

CDC Helpful Documents

The CDC has provided a checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025) as well as a website (http://www.cdc.gov/drugoverdose/prescribingresources.html) with additional tools to guide clinicians in implementing the recommendations.

Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction

The Centers for Medicare and Medicaid Services (CMS) has issued an Informational Bulletin to help prevent opioid-related harms. Medicaid beneficiaries are prescribed painkillers at twice the rate of non-Medicaid patients. Methadone, once again, accounts for a disproportionate amount of overdose-related deaths. PDMPs are continually recommended to monitor opioid prescribing and patient safety. States can consider strategies to increase the availability of naloxone products and provide substance use disorder treatment services. Naloxone is used to completely or partially reverse narcotic depression, including respiratory depression, sedation, and hypotension. Naloxone is available in a syringe or nasal spray device, along with a branded auto-injector form.

For those with the capability to prescribe buprenorphine, CMS has issued a Drug Diversion Toolkit available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/drugdiversion-buprenorphine-booklet.pdf.

References:

Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2016. Recommendations and Reports 2016 Mar. 18; 65(1): 1-49. Available at http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. CMCS information bulletin: best practices for addressing prescription opioid overdoses, misuse and addiction. 2016 Jan. 28. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf.

Generic Medications

Recently Approved Generic Drugs:

March 2016	April 2016	May 2016
Oxiconazole cream (Oxistat Cream)	Rosiglitazone/glimepiride (Avadaryl)	Diclofenac (Cambia)
Sildenafil tablets (Viagra)	Flurandrenolide cream (Cordran Cream)	Estradiol/diengest (Natazia)
Diclofenac 1% gel (Voltaren Gel)	Fosamprenavir tablets (Lexiva)	Rufinamide (Banzel)
Mometasone nasal spray (Nasonex)	Lacosamide (Vimpat)	Doxycycline DR (Doxteric DR)
Levonorgestrol/EE tablets (Quartette)	Rosuvastatin (Creastor)	Norethindrone/EE (Minatrin 24 Fe)
		Febuxostat (Uloric)

Upcoming Generic Drugs:

Generic Name	Brand Name	Anticipated Launch
Armodafinil	Nuvigil	June 1, 2016
Clindamycin phosphate, Tretinoin	Ziana	June 1, 2016
Omeprazole, Sodium bicarbonate	Zegerid	July 16, 2016

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